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August 14, 2003

Secretary Marlene Dortch
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Exparte filing:
In the Matter of the Rural
Healthcare Support Mechanism
WC 02-60

Dear Secretary Dortch,

We are writing to supplement our previously filed comments regarding the Notice of Proposed Rulemaking (Docket WC 02-60) regarding the Rural Healthcare Support Mechanism. We believe that in the interest of public safety and to enhance the health status of our rural citizens, it is within the jurisdiction of the FCC to justify an expansion of the statutorily defined eligible healthcare providers.

In this regard, we urge the FCC to make note of the significant role telemedicine technologies currently play in the delivery of critical healthcare services to our rural citizens, and an anticipated significantly greater impact, when facilitated by an expanded deployment of broadband connectivity. By crafting rules that create an infrastructure that further promotes timely access to acute specialty healthcare services, chronic disease management programs and preventive services and to health professional education, the FCC is uniquely positioned to converge both the vision and the express mandate of the Congress.

As noted in the reply comments to the NPRM submitted by U. S. Representative Rick Boucher, "disappointingly few of the 8,297 rural healthcare providers participate in the program, yet our rural residents continue to have only limited access to the type of telehealth and telemedicine programs envisioned by the policymakers who established the program."

In the Telecommunications Act of 1996, the relationship between Universal service and public safety is clearly addressed.[1] "The Joint Board in recommending, and the Commission in establishing, the definition of the services that are supported by Federal universal service support mechanisms shall consider the extent to which such telecommunications services--

(A) are essential to education, public health, or public safety....[and]

(D) are consistent with the public interest, convenience, and necessity."

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The Telecommunications Act of 1996 identifies healthcare providers eligible to receive discounts under the auspices of the Rural Healthcare Support Mechanism by identifying the following entities as eligible:

1. post secondary educational institutions offering healthcare instruction, teaching hospitals, medical schools;
2. community health centers or health centers providing healthcare to migrants;
3. local health departments or agencies;
4. community mental health centers;
5. not-for-profit hospitals;
6. rural health clinics; and
7. consortia of health care providers consisting of one or more entities described in clauses 1-6."[2]

In an expanded definition of the six statutorily defined entities eligible for telecommunications discounts, we propose that it is feasible to justify providing support to any rural hospital (not-for-profit or for-profit) with a functioning emergency department. Such entities are indisputably "essential to public health and public safety". Such entities (for profit and not for profit) are also bound by all federal regulations such as the federal Emergency Medical Treatment And Labor Act (EMTALA) which requires that individuals who present at a hospital and request treatment for a medical condition receive appropriate care as rapidly as possible.[3] Section (c)(1) of EMTALA states that "if an individual at a hospital has an emergency medical condition which has not been stabilized...the hospital may not transfer the individual unless--(A)(ii) a physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual.." This statute applies equally to for-profit and not for profit emergency medical entities, and supports our recommendations for expanded eligibility for selected providers.

In support of this proposal, we suggest that the FCC consider the "real world" role of rural emergency rooms (considered outpatient facilities), which all too often serve the public as a "rural health clinic", though not identified as such. In most communities, emergency rooms are the only ambulatory care entities that are open 24 hours/day, seven days/week. The Center for Medicare and Medicaid Services defines a "rural health clinic" as "*an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.*" [4]

In further support of our position in this regard, the FCC should note that the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) applies ambulatory care standards to emergency room surveys. JCAHO defines Ambulatory Health Care and Outpatient Medical Services as follows: "**Outpatient medical**

services.... An environment providing care to clients on an ambulatory basis, i.e. to clients not admitted to the organization for a 24-hour stay. A visit is counted when a client receives services by a distinct department. An outpatient visit can be provided through clinical departments and/or an organized outpatient ambulatory care program. The visits may take place within the hospital, on its campus or at an off-site location."[5]

Emergency departments are the logical point of entry into the healthcare system for any patient suffering the consequences of a bioterrorist, chemical or nuclear catastrophe. Thus, in service of public safety, and because of their functionality as a "rural health clinic", the FCC should consider any rural hospital with an emergency department as eligible for telecommunications discounts via the Rural Healthcare Support Mechanism.

In the Commonwealth of Virginia, currently there are only five hospitals that meet the criteria as rural, for-profit, and are located within a medically underserved area. If extrapolated to 50 states, extending rural healthcare support to an additional 250 entities will not greatly increase the number of eligible health care entities (from the current number of 8,297).

There is also some justification for providing discounted telecommunications services to rural nursing homes in medically underserved areas, wherein a clinical office within that unit could be reasonably considered a "rural health clinic" providing care to residents who would otherwise be required to travel, with significant hardship, long distances to an outpatient facility for specialty care.

While cumbersome to implement, pro-rating of discounts could be applied to those entities that choose to use the connectivity for non-eligible purposes as well. We recommend that discounts be applied on a percentage basis *through documentation of non-eligible uses*; we believe it is critical that the baseline denominator of connectivity be measured at 24 hours per day, 7 days per week, the hours of operation of any emergency department. As for pro-rating of discounts for *non-eligible entities* (such as rural for-profit hospitals with emergency rooms as proposed above), if the FCC deems it critical, a metric could be selected such as that which we proposed in our initial comments, i.e., % gross revenues in care provided to federal beneficiaries (Medicare and Medicaid), a commonly reported statistic.

We believe the FCC now has a unique opportunity, both in this rulemaking process *and* in its new Homeland Security initiative, to resolve many of the issues that have led to the drastic underutilization of the Rural Healthcare Support Mechanism, and to promote enhanced rural considerations in our national state of emergency preparedness. It is our hope that the FCC seriously consider these proposed recommendations in the crafting of new rules applied to the Rural Healthcare Support Mechanism.

Sincerely,

Karen S. Rheuban, MD
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Office of Telemedicine
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Director

[1]Telecommunications Act of 1996, 47 U.S.C. 609 Section 254 7 (C) 1
[2] Id at Section 254 5 (B)
[3] 42 USC 1395dd.
[4] http://www.cmms.gov/glossary/
[5] http://www.jcaho.org